

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

0396

1. PLACE OF DEATH

County

Charles

Registration Dist. No.

107

Village or City

Somphinsville

St.

Ward

Length of residence in city or town where death occurred 86 yrs., mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

(a) Residence: No.

(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Black	MARRIED

Se. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Ella Frances Burroughs

6. DATE OF BIRTH (month, day, and year)

Oct 16, 1880

7. AGE	Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
86	6	24	1	1 day, _____ hrs. or _____ min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation
	Dental Labored		June 1937	

12. BIRTHPLACE (city or town) (State or country)	13. NAME
Md - Charles	Lewis Burroughs

14. BIRTHPLACE (city or town) (State or country)	15. MAIDEN NAME
Somphinsville, Ky	Elizabeth Somphinsville

16. BIRTHPLACE (city or town) (State or country)	17. INFORMANT
Charles	Ella Frances Burroughs

18. BURIAL, CREMATION, OR REMOVAL Place	19. UNDERTAKER (Address)
Buried	Austin Rogers

20. FILED	(Signed)
5/10, 1947 — William J. Hale Registrar	J. F. Hargrove M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

May
(Month)10
(Day)1947
(Year)

22. I HEREBY CERTIFY. That I attended deceased from 4-21-1947, to 5-10-1947

I last saw him alive on 5-8-1947; death is said

to have occurred on the date stated above, at 5:30 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Hepatic degeneration
inflammation to liver

Date of onset

Other Contributory Causes of Importance:

Name of operator _____ Date of _____

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicida? Date of injury _____, 19_____

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed)

(Address)

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago

MAY 12 1947

Other contributory causes of importance:

	Other contributory causes of importance:	
Gallstones	Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

13963

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

5 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ela S. Clancey

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

B.(b) Name of husband or wife

Michael Clancey

7. Birth date of deceased (mo., day, yr.)

April 17 1868

6.(c) If alive, give age years

75-

8. AGE:

Years
79Months
24

Days

If less than one day
hrs. min.

9. Birthplace

Crossville, Clarke Co. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Peter Wheeler

12. Name

Virginia

13. Birthplace

Maggart Poole

14. Maiden name

Charles Co. Md.

15. Birthplace

Lessie Milstead

16. Informant

Neil Twp, Md.

Address

Burial

Date thereof
(month) (day) (year)
May 18 '47

(Burial, cremation, or removal which?)

Cemetery or crematory

St. Charles

Location

Indiana Head Md.

18. Funeral director

Dent & Ryan

Address

Waldorf Md.

19. May 12 1947

(Date reg'd by registrar)

Many Smithland
Local

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) if veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 11 1947 at 11⁵

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on May 9 1947

Immediate cause of death

Cardio-vascular
renal disease.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

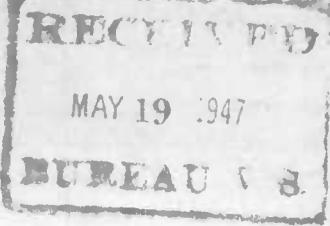
Geo. O. Becknell M.D.

M. D. or other

Address

Marbury Md.

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03964

97

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County Charles

City or town La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Randall Clark

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 15, 1856

6.(c) If alive, give age

years

8. AGE:

Years
90Months
4Days
28

If less than one day

hrs. min.

9. Birthplace Philadelphia, Pennsylvania

(Town, county, and state)

10. Usual occupation Retired farmer

11. Industry or business

12. Name John Randall Clark

13. Birthplace London, England

14. Maiden name Ellen Harrington

London, England

15. Birthplace Miss Viola K. Clark

Address La Plata, Maryland

17. Burial Date thereof 5-20-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mount Rest

Location La Plata, Maryland

18. Funeral director Hunt & Ryon

Address Waldorf, Maryland

19. 5/19/47 19 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles

City or town La Plata (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 17 1947 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 3 1940 to May 17 1947 and that I last saw him alive on May 17 1947

Immediate cause of death

Generalized Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed 5-19-47

RECEIVED

MAY 21 1947

BUREAU OF E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03965

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:

County CHARLES

City or town INDIAN HEAD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 YEARS

Hospital, institution, or street address where death occurred:

103 HOLDEN ROAD

How long in hospital or institution?

3. (a) FULL NAME

VOLNEY HOWARD DRINKARD

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife

FLETA C. DRINKARD

7. Birth date of deceased (mo., day, yr.)

APRIL 19 1889

6.(c) If alive, give age

58

years

8. AGE:

Years

Months

Days

It less than one day

58

1

5

hrs.

min.

9. Birthplace

LYNCHBURG, VA.

(Town, county, and state)

10. Usual occupation

MACHINIST

11. Industry or business

NPF INDIAN HEAD, MD.

MOTHER FATHER

12. Name GLOVER DRINKARD

MOTHER FATHER

13. Birthplace CAMBELL COUNTY VIRGINIA

MOTHER FATHER

14. Maiden name ROSIE W. CARDWELL

MOTHER FATHER

15. Birthplace CAMBELL COUNTY VIRGINIA

16. Informant

GROVER C. DRINKARD

Address

INDIAN HEAD, MD.

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof May 27 1947

(month) (day) (year)

Cemetery or crematory

MARBURY BAPTIST CHURCH CEM.

Location

MARBURY, MD.

18. Funeral director

HUNT + RYAN

Address

WALDORF, MD.

19. Date rec'd by registrar

May 24 1947

(Date rec'd by registrar)

Odey Price

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County CHARLES

City or town INDIAN HEAD

(If outside city or town limits, write RURAL and give nearest town)

Street No.

103 HOLDEN ROAD

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

MAY 24

19 47

at 3:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

APRIL 26

19 47, to MAY 17

19 47

and that I last saw h.m. alive on MAT 17

19 47

Immediate cause of death ANOXIA

DURATION

Due to PULMONARY TUBERCULOSIS - FAR ADVANCED

4 YEARS

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

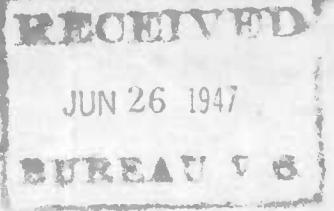
Frederick W. Reichardt

M.D.

M. D. or other

Address INDIAN HEAD, MD.

Date signed 5-24-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct are
especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

03966

Reg. Dist. No. 100

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County CharlesCity or town Bryans Road

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

U.S. Highway 224

How long in hospital or institution?

3. (a) FULL NAME

William A. Dyson

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MaleNegroMarried

6.(b) Name of husband or wife

Annie King Dyson6.(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.)

June 29, 1904

8. AGE:

421019

If less than one day hrs. min.

9. Birthplace

Bryans Rd, Charles, Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

William Dyson

MOTHER FATHER

12. Name

Charles C. Ind

13. Birthplace

Mallie Brown

14. Maiden name

Charles Co., Ind

15. Birthplace

Hattie Carter

16. Informant

Burke

Address

719 - R.J. Ave N.W. Wash, D.C.

(Burial, cremation, or removal? Which?)

Date thereof 5-28-47

(month) (day) (year)

Cemetery or crematory

Pomona Cemetery

Location

Charles Co., Ind.

18. Funeral director

Hunt & Ryan

Address

Wadley, Ind

19. Date rec'd by registrar

5-20 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County CharlesCity or town Bryans Road

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 18, 1947, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

on May 18 1947 toand that I last saw him alive on May 18, 1947

Immediate cause of death

Crushed chestDue to Auto accidentDue to Hit by auto

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide AccidentDate of 5-18-47Where did injury occur? Bryans Road, Charles, Md.

(City or town)

(County) (State)

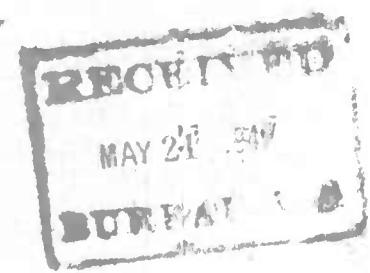
Injured at home, farm, industry, public place (where?) Street roadMeans of injury Hit by autoInjured at work? No

Deputy Medical Examiner

23. SIGNATURE James J. MacKenna, M.D.

M. D. or other

Address S. Plaza, Md Date signed 5-18-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

466

CERTIFICATE OF DEATH

03867

Reg. Dist. No. 13867

1. PLACE OF DEATH: Charles
County: Charles

City or town: Rural Newmarket
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 years

Hospital, institution, or street address where death occurred:

Route #6 - Newmarket - La Plata

How long in hospital or institution?

3. (a) FULL NAME

Carl Geppert

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife	Emma Geppert
6. (c) If alive, give age	73 years

7. Birth date of deceased (mo., day, yr.)	Jan. 27, 1876
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8. AGE:	Years 71	Months 4	Days 2	If less than one day hrs. min.
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9. Birthplace	Conney, Poland (Town, county, and state)
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10. Usual occupation	Farmer
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11. Industry or business	Farmer
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MOTHER FATHER	12. Name	Gustaf Geppert
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	13. Birthplace	Conney Poland
--	----------------	---------------

	14. Maiden name	Emma Clerber
--	-----------------	--------------

	15. Birthplace	Conney Poland
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16. Informant	Mrs. Carl (Emma) Geppert
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Address	Route #6 - Rural (Newmarket) Charles
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17. Burial	Date thereof	JUNE 21 1947
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(Burial, cremation, or removal. Which?)	(month)	(day)	(year)
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Cemetery or crematory	WASHINGTON NATIONAL
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Location	Suitland md
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18. Funeral director	ELMER M. QUADE
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Address	Hughesville md
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19. Date rec'd by registrar	JUNE 1 1947
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2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Charles

City or town Rural Newmarket
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route #6 - Newmarket - La Plata
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 1947, to May 29 1947 and that I last saw him alive on May 14 1947

Immediate cause of death.

Circulatory failure

DURATION

3 weeks

Due to Anemia, secondary

1 year

Due to Carcinoma of Stomach
with metastases to liver

?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Francis J. Cullen, M.D. or other

Address Hughesville, Md. Date signed 5-29-47

RECEIVED

JUN 1 1947

BUREAU F B I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1940

CERTIFICATE OF DEATH

Reg. Dist. No.

05968
106

1. PLACE OF DEATH:

County

Charles
Rural (Bryans Road)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Samuel Johnson

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Colored Male Married

6.(b) Name of husband or wife

Bessie Johnson

7. Birth date of deceased (mo., day, yr.)

1894

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

North Carolina

10. Usual occupation

Laborer

11. Industry or business

Construction Work

12. Name

Eddie Johnson

S.C.

13. Birthplace

S.C.

14. Maiden name

S. C.

15. Birthplace

S. C.

16. Informant

Alec Queen

Address

Bryans Road, Md.

17. Burial, cremation, or removal (Which?)

Burial Payne Cemetery

Date thereof May 2d, 1947
(month) (day) (year)

Cemetery or crematory

Payne Cemetery

Location

Washington, D. C.

18. Funeral director

Penning & Coker

Address

Mason Springs, Md.

19. Date rec'd by registrar

Ody Queen

(Dated rec'd by registrar)

Registrar

5/15/47 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Washington, D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1740 1/2 St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

X

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 15

1947 21 6³⁰

I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

19...

and that I last saw h... alive on

19...

Immediate cause of death

Poisonous result of
drinking Methyl Alcohol
(Caused Heat in
body)

DURATION

24 days

Death Wash. D. C. about 5/13/47
(Friend died in Wash.)DC 5/13/47 of same
cause as both were
drinking together

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. ~~Violent~~ Death was due to _____ fill in the following:

Accident, suicide, or homicide

Accident

Date of

5/13/47

Where did injury occur?

Washington, D. C.

(City or town)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Franklin Susan L. L.

M. D. or other

5/15/47

Address Indian Head & Old Date signed

2. 5. 1947

2. 5. 1947

2. 5. 1947

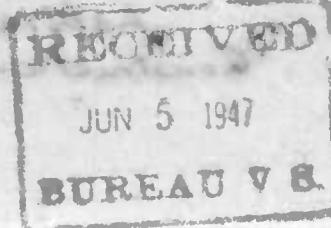
2. 5. 1947

2. 5. 1947

2. 5. 1947

2. 5. 1947

2. 5. 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03969

83d

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:

County

Charles
Bryant's Road Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6.8 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Elizabeth Key

4. Sex

Female Col. Married

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

James W. Key Sr.

7. Birth date of deceased (mo., day, yr.)

Dec. 2. 1878

6.(c) If alive, give age 72 years

8. AGE:

Years Months Days If less than one day
68 5 18 hrs. min.

9. Birthplace

Bryant's Road. Md.

(Town, county, and state)

10. Usual occupation

Housewife

Own Home

11. Industry or business

FATHER

12. Name John Marbury

13. Birthplace

Charles Co. Md.

MOTHER

14. Maiden name

Matthews NEAL Marbury

15. Birthplace

Charles Co. Md.

16. Informant

James W. Key Jr.

Address

Bryant's Road. Md.

17. Burial, cremation, or removal. Which?

Date thereof May 1947

(month) (day) (year)

Cemetery or crematory

Metropolitan M.E. Church

Location

Pomona Key. Md.

18. Funeral director

Matthews & Associates

Address

Wash. D. C.

19. Date rec'd by registrar

1947

(Date rec'd by registrar)

M. E. Parsons
Deputy Clerk Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Old County Charles

City or town Bryant's Road (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 20 1947 at 4:52 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 26 1947 to May 20 1947

and that I last saw her alive on May 20 1947

Immediate cause of death

Empyema Right lung.

DURATION

1 month

Due to Unresolved Phenomenon

6 weeks

Due to

Other conditions R.T. Hemiplegia

4 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

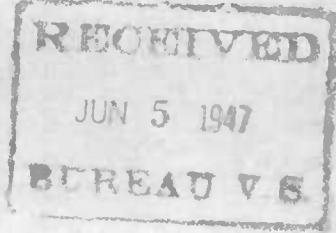
Injured at work?

23. SIGNATURE

Sam G. Lason M.D.

M. D. or other

Address T. A. H. Head Old Date signed 5/20/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

03970

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH:

County

City or town

Charles
Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

W

Married

6. (b) Name of husband or wife

Rose Lawrence

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age 72 years
1867

8. AGE:

Years

Months

Days

Less than one day

hrs.

min.

9. Birthplace

Somerset Maryland

(Town, county, and state)

10. Usual occupation

Waterman

11. Industry or business

Westley Lawrence

MOTHER FATHER

Name

Westley Lawrence

Birthplace

Unknown

Maiden name

Hector Bausman

Birthplace

Unknown

16. Informant

Mrs. Rose Lawrence

Address

Baltimore Md.

17. Burial

(Burial, cremation, or removal; which?)

Date thereof May 19 47

(month) (day) (year)

Cemetery or crematory

Baptist

Location

Nanjimy Md.

18. Funeral director

Hunt & Ryan

Address

Valdert St Md.

19. May 17 1947

(Date rec'd by registrar)

Maryland Deathland
Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Maryland County Charles

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 16 1947 at 9³⁰

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1947 to May 1947 and that last saw him alive on May 15 1947

Immediate cause of death

Influenza of Age -

Due to

Enterovirus

Acute Nephritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

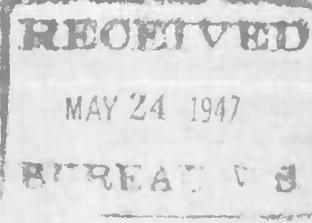
Injured at work?

23. SIGNATURE

M. D. or other

Address

George C. Bicknell Jr.
Maryland Md. May 17 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 105

13971

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

6. (b) Name of husband or wife

7. Birth date of deceased (m/o, day, yr)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Ches Co Md

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER

12. Name.....

George Roy

Tompsonville MD

13. Birthplace.....

14. Maiden name.....

Eliza Fowler

Tompsonville MD

15. Birthplace.....

16. Informant.....

Burrill

Address.....

Burial

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar)

Registrat

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

County

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

5-25

1947

at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

O'Brien's Case

1947

and that I last saw him alive on

18.

Immediate cause of death.....

Tubercular Hemorrhage

DURATION

Due to.....

Tuberculosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Signature

M. D. or other

Date signed

RECEIVED

MAY 28 1947

BUREAU F.B.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46e

03972

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH:

County

City or town

Charles

Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Repose Home

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Annie Limmons (Montgomery)

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

John Montgomery (common law)

7. Birth date of deceased (mo., day, yr.)

6 (c) Alive, give age years

1901

8. AGE:

46

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Maryland (Charles Co. Md.)

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name

Waters

13. Birthplace

Charles Co. Md.

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Bernice Cowington

Address

Washington D.C.

17. Burial

Date thereof May 17 47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Smith Chapel

Location

Picard Rd

18. Funeral director

R. King's

Address

Washington Co

19. Date rec'd by registrar

1947

May 14 1947 Maryland local

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State _____ County _____

City or town _____ (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1947 at 59

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1947 to May 1947 and that I last saw her alive on May 1947

Immediate cause of death

Intestinal Carcinoma

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

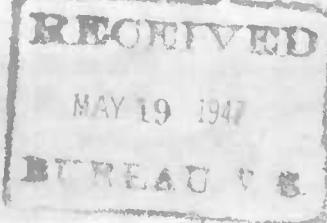
23. SIGNATURE

Geo. C. Bicknell M.D.

M. D. or other

Address May 14 47

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03973

488

CERTIFICATE OF DEATH

Reg. Dist. No.

106

1. PLACE OF DEATH:

County.....

Charles

City or town.....

Rural Indian Head

How long in above place of death?.....

28 years

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Edgarine Swann Thompson

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female Colored married

6.(b) Name of husband or wife.....

George S. Thompson

7. Birth date of deceased (mo., day, yr.)

March 1, 1900

6.(c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

47 2 9 hrs. min.

9. Birthplace.....

Bel Alton, Md

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

Own Home

12. Name.....

James Swann

13. Birthplace

Bel Alton, Md

14. Maiden name

Edna Proctor

15. Birthplace

Bel Alton, Md.

16. Informant.....

George S. Thompson

Address

(P.O. Pisgah, Md.)

17. Burial

Date thereof May 12 1947

(month) (day) (year)

(Burial, cremation, or removal, Which?)

Cemetery or crematory

St Charles

Location

Glymont, Md.

18. Funeral director

Penny & Cofey

Address

Mason Springs, Md

19. Date rec'd by registrar

1947

(Date rec'd by registrar)

Odey Price

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md.

County

Charles

City or town.....

Rural Indian Head

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 10

1947 at 5A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 5, 1947, to May 10, 1947

and that I last saw her alive on May 8, 1947

Immediate cause of death

Cerebrovascular accident

DURATION

1 year

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

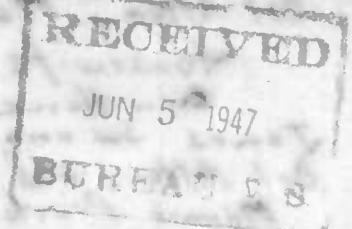
23. SIGNATURE

Frances Susan M. S.

M. D. or other

Address

Indian Head, Md. Date signed 5/10/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13974

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County.....

Charles

City or town.....

La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

1 week

Hospital, institution, or street address where death occurred:

Physician's Memorial Hospital

How long in hospital or institution?.....

1 week

3. (a) FULL NAME

Pleasant Lucille Wood

4. Sex

F

5. Color or race

Negro

6.(a) Single, married, widowed, or divorced

Married.

6.(b) Name of husband or wife.....

John Wood

7. Birth date of deceased (mo., day, yr.)

July 9, 1911

6.(c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

35.

9

26

hrs.

min.

9. Birthplace.....

Charles County, Md.

(Town, county, and state)

10. Usual occupation.....

Waitress

11. Industry or business

Aley Shuster

12. Name.....

Chesapeake Co., Md.

13. Birthplace

Chesapeake Co., Md.

14. Maiden name.....

Mary Lyle

15. Birthplace

Chesapeake Co., Md.

16. Informant.....

John Wood

Address

White Plains, Md.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof.....

5-7-47

(month) (day) (year)

Cemetery or crematory.....

St. Joseph's

Location.....

Parsonage, Md.

18. Funeral director.....

Heath & Ryan

Address

Waldorf, Md.

19. (Date rec'd by registrar)

5-7-47

19 47

John H. Pacey

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Charles

City or town.....

White Plains

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 5

19 47, at 11:24 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 29 1947, to May 5 1947
and that I last saw her alive on May 5 1947

Immediate cause of death..... Respiratory Paralysis DURATION

Due to..... Toxic Medullary Depression

Due to.....

Other conditions..... Inoperable Malignancy

C metastasis (Retropertitoneal Sarcoma)

(Include pregnancy within 3 months of death)

Major findings of operations..... Malignancy - Retropertitoneal
Sarcoma - inoperable Date of op. May 5/47

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

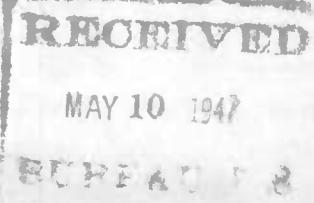
Injured at home, farm, industry, public-place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... La Plata, Md. Date signed 5-6-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03375

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH: Charles
 County: Pomonkey
 City or town: Pomonkey
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 88 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Md. County: Charles
 City or town: Pomonkey
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.:
 (If rural, give LOCATION)

3. (a) FULL NAME John C. Young

4. Sex <u>Male</u>	5. Color or race <u>Colored</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>	
6. (b) Name of husband or wife <u>Ella Ray Young</u>		6. (c) If alive, give age <u>years</u>	
7. Birth date of deceased (mo., day, yr.) <u>2 - 14 - 59</u>		6. (d) If alive, give age <u>years</u>	
8. AGE: Years <u>88</u>	Months <u>2</u>	Days <u>29</u>	It less than one day <u>hrs.</u> <u>min.</u>
9. Birthplace <u>Pomonkey</u> <small>(Town, county, and state)</small>			
10. Usual occupation <u>Labourer (Retired)</u>			
11. Industry or business <u>U.S. Govt.</u>			
12. Name <u>Not Known</u>			
13. Birthplace <u>Not Known</u>			
14. Maiden name <u>Not Known</u>			
15. Birthplace <u>Not Known</u>			
16. Informant <u>Wesley S. Jordan</u>			
Address <u>Pomonkey Md.</u>			
17. (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>May 15 1947</u> <small>(month) (day) (year)</small>			
Cemetery or crematory <u>Metropolitan M.E. Church</u>			
Location <u>Pomonkey Md.</u>			
18. Funeral director <u>Dorothy Matthews</u>			
Address <u>614-145 St. S.W. Wash. D.C.</u>			
19. Date rec'd by registrar <u>5/13 1947</u> Signature <u>Oleg Price</u> Registrar			

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947 at 1A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1947, to May 13 1947, and that I last saw him alive on May 10 1947.

Immediate cause of death Chronic Oxyocarditis

Due to <u>Senility</u>	DURATION <u>2 years</u>
Due to <u></u>	<u>4 years</u>
Other conditions <u>Chronic prostatic Obstruction</u> <u>12 yrs.</u>	

(Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Franklin Susan L. D.

M. D. or other

Address Indian Head Md. Date signed 5-13-47

RECEIVED

JUN 5 1947

BUREAU V.S.